

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-005012

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 3000 Primary Registration District No. 59 Registrar's No. 59

FILLED FEB 25 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kirksville</u>		c. CITY OR TOWN <u>Kirksville</u>	
Length of stay in 1b <u>years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>303 W. Pierce</u>		d. STREET ADDRESS (If outside, give location) <u>303 W. Pierce</u>	
3. NAME OF DECEASED (Type or print) <u>ALFRED FOX</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/99</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	
13a. FATHER'S NAME <u>Henry C. Fox</u>		13b. MOTHER'S MAIDEN NAME <u>Samantha Ellen March</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>Ruth Fox, Kirksville, Mo.</u>		14. NAME OF HUSBAND OR WIFE <u>Ruth Scobee Fox</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary heart disease</u>		7 yrs	
DUE TO (c) <u>Arteriosclerosis</u>		Unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Viral Gastroenteritis 3 days</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I, or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>4:50 p</u> Month, Day, Year <u>7-22-46</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Kirksville, Mo.</u>		20f. CITY, TOWN, OR LOCATION <u>Kirksville, Adair, Mo.</u>	
21. I attended the deceased from <u>7-22-46</u> to <u>2-13-63</u> and last saw him alive on <u>2-13-63</u> Death occurred at <u>4:50 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>[Signature]</u> (Degree or title)	
22b. ADDRESS <u>311 E. Harrison Kirksville, Mo.</u>		22c. DATE SIGNED <u>2/15/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 16/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Park</u>	
24. FUNERAL DIRECTOR <u>Foster Memorial Home, Kirksville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb 18, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		27. ADDRESS <u>[REDACTED]</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

No permit issued

Ed. Bestmann, D.O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Anna E. Foster

Licensed Embalmer No.

4742

P. O. Address

Kirkville Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.